PRINTED: 04/23/2008

04/23/2008 03:56 FAA Z0Z44Z9430

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	rs for medicare		FORM APPROVED OMB NO. 0938-0391					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, -7	(XX) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		096035	B. WING			R 04/04/2008		
CM 3	PROVIDER OR SUPPLIER		STREET ADDRESS. CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010					
(X4) IID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XF	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION CATE	
(W 000)	was initiated on 4/3 4/4/2008. The sun the level of complia the previous report of Correction (POC were based on obs well as a review of records, including a reports.	TS 2/14/2008 recertification survey 3/2008 and was completed on vey was conducted to assess ance to the deficiencies cited in and as presented in their Plan c). The results of the survey rervation, staff interviews, as the client and administrative a review of the unusual incident FF TREATMENT OF	(W 0	•	GOVERNMENT OF THE DISTRIC DEPARTMENT OF HE HEALTH REGULATION ADM 825 NORTH CAPITOL ST., N.I WASHINGTON, D.C.	TIOF COEU EALTH IINISTRATIO E., 2ND FLOO 20002	NBIA R	
•• 140)	CLIENTS The facility must de policies and proces	evelop and implement written	(44.)	· 	The facility will provi ing on incident managem reporting injuries to staff.	ent, and		
-	Based on staff inte facility falled to ens written policies and	is not met as evidenced by: rview and record review, the rure the implementation of its procedures as required by lients residing in the facility.						
	The finding include	s: ed during the 2/14/2008 survey						
-	for falling to implen	nent policies on reporting of The provider 's Plan of						

Any deficiency statement ending with an extensit (') denotes a deficiency which the institution may be accused from correcting providing it is determined that other sateguards provide sufficient protection to the patients. (See instructions.) Except for questing homes, the findings stated above are disclossable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above tradings and plans of correction are disclossable 14 days following the date these documents are made svalighte to the facility. If deficiencies are chied, an approved plan of correction is requisite to continued program participation.

Correction (POC) detailed that "in the future ... staff will be required to attend additional training on Incident Management Policies and reporting injuries to Nursing staff." Interview with the facility 's Qualified Mental Retardation Professional (QMRP) on 4/3/2008 at 3:11pm revealed there has been no training on the incident management policy or on the

methodology of reporting injuries to the Nursing

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1. (A HURDING COMPLETE		TED CET	
		09 G 035	B. Wit	4G_			₹ 4/2008
NAME OF P	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 112 13TH STREET NW VASHINGTON, DC 20018		
(744) IID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE FRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ALD BE	(X5) COMPLETION DATE
(W 149) (W 159)	staff since the 2/14, 483,430(a) QUALIF RETARDATION PER Each client's active integrated, coordinated mental retained from the STANDARD is active treatment proceeding and mental Retardation clients residing in the findings included. The Qualified Mercelvad the proper client's orthotic de 2. The Qualified Mercelsonal (QMR received the proper client's orthotic de 2. The Qualified Mercelsonal (QMR oversight and monity and professional (QMR oversight and monity and mental and monity and monity and mental and monity and monity and monity and mental a	2008 survey. FIED MENTAL ROFESSIONAL treatment program must be ated and monitored by a ardation professional. s not met as evidenced by; on, staff interview and record alled to ensure each client's agram was integrated, anitored by the Qualified Professional (QMRP) for two me facility. [Clients #1 and #4] E. Mental Retardation P) failed to ensure staff and necessary training on a vice. [Reference W189]	{W 1	•		thorize device writt when r the l provi nt#1 was his o his cumentat lental l retur an atte	5/15/08 de 5/15/08 ion
ļ		P) failed to ensure clients and necessary dental		:			
,		P) also failed to ensure client ' er and necessary adaptive		:			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	i
CENTERS FOR MEDICARE & MEDICAID SERVICES	_

	FOF DEFICIENCIES OF CORRECTION	(X1) PROMDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(XZ) MI A. BUIL		PLE CONSTRUCTION	(XX) DATE SA COMPLE	
,		89G035	8, WIN	g_		₹ 54/84/2 008	
NAME OF F	ROVIDER OR SUPPLIER	•		31	KET ADDRESS, CITY, STATE, ZIP CODE 112 13TH STREET NW (ASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFU TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		ALD BE	COMPLETION DATE
{VV 189}	The facility must pro initial and continuing	FF TRAINING PROGRAM ovide each employee with g training that enables the m his or her duties effectively, petently.	(W 18	39}	QMRP will provide trains staff once Client#4 rec. his braces.		6/1/08
	Based on observati review, the facility for received the proper client's adaptive e	s not met as evidenced by: on, staff interview and record alled to ensure that staff and necessary training on a quipment as required by this ight clients residing in the					
	for failing to ensure Client #4's adaptiv brace). The facility detailed that "the f assist [Client #4] in	id during the 2/14/2008 survey that staff received training on re equipment (gait belt and leg 's Plan of Correction (POC) facility will train staff on how to walking with the gait belt and se. "This corrective measure					
	A/4/2008 wearing his leg brace. Staff beft, but it was not on his leg brace. Inter Qualified Mental Re(QMRP) on 4/4/200 braces were not award that the provision pending. Record renot able to complete	rved on the affatnoon of is galt belt but, he was without if was observed using the gait clear why he was not wearing view with the facility's elardation Professional is at 3:37pm revealed the legaliable at the time of survey on of that orthotic device was eview revealed the facility was a the training on the use of the lat the orthotic device has not alternoe W436]					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 04/23/2008 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES OF CORRECTION	(X1) PRÖVIDÉR/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTI	PLE CONSTRUCTION	(X9) DATE 6 COMPL		
		09 G 035	B. WING _		R 04/04/2008		
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	.3	REET ADDRESS, CITY, STATE, ZIP CODE 112 13TH STREET NW VASHINGTON, DC 20010			
(XA) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	1D PREFIX TAG	(EACH CORRECTIVE ACTION SHOT	PROVIDERS PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 257	483.440(f)(1)(iii) PRCHANGE The individual programs by the qualifier professional and restrict the facility for progress to after reasonable efficiency for the facility failed to addition progression by a clipad facility failed to addition progression for the facility was previously cited program during the was previously cited requirements as lated on 4/4/2008 at 3:45 been refusing the first three steps program are as followed.	ram plan must be reviewed at dimental retardation vised as necessary, including, uations in which the client is oward identified objectives onts have been made. In not met as evidenced by: view and record review the ress the documented lack of ant on his self medication ram one of eight clients by. [Client #1] It viously cited for failing to cumentation on a client's 2/14/2008 survey. The facility if for failing to meet the count in W252. Record review pur revealed Client #1 has stince the date of survey.	W 257			5/15/08	
	 Will pour cup of Will punch out r Interview with the fa Retardation Profess revealed she was no progressing poorly r 						

84/23/2886 83:00 PAA 2024428400

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(NZ) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
,		09G035	B, WI	€		1	4/2008
NAME OF P	ROVIDER OR SUPPLIER			3	RET ADDRESS, CITY, STATE ZIP CODE 112 13TH STREET NW VASHINGTON, DC 20010		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREF TAG		PROMDERS PLAN OF CORRECT (BACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	VLD BE	COMPLETION CATE
W 257 (W 356)	the proper supports show progress in a	gs 4 t and intervention to ensure s when a client 's is failing to habilitation program. IPREHENSIVE DENTAL	: W E W}		Cross reference W159		5/L\$\(\disploy\)
	treatment services needed for relief of	isure comprehensive dental that include dental care pain and infections, and maintenance of dental					
	Based on staff inter facility falled to ens necessary dental s of eight clients resi	s not met as evidenced by: rview and record review, lite ure the provision of timely and ervices and treatment for one ding in the facility. [Client #1]					
	timely dental service to the citation levier the facility took the services on 2/18/201/29/2008, but the following services.	e: eviously cited for not ensuring les for its residents. According d during the 2/14/2008 survey, client to receive dental 207, 7/16/2007, and again on client did not received the The reason(a) why the ender was unknown to the	•				
	heavy calculus dep 2. Recommended 3. Treatment to a 4. Treatment to a Tooth #12	i to receive scaling due to osits it to receive partial denture ddress Ginglvitis ddress the Carlous lesion on it to receive Prophylaxis and				-	

#194 P. 007/015

84/23/2808 03:57 FAA 2024428480

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	1, 7		PLE CONSTRUCTION	(DCI) DATE SI COMPLE	
			A. BU)			ļ	R
		D9 G035	B, Wil	(G_		04/0	4/2008
NAME OF P	ROVIDER OR SUPPLIER			31	EET ADDRESS, CITY, STATE, ZIP COPE 12 13TH STREET NW /ASHINGTON, DC 20010		
(XA) ID PREHIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOW CROSS-REPERENCED TO THE APPR DEFICIENCY)	ULD BE	(ZE) CECIMIPLETION CATE
(W 356)	that they would ensite the dentist for de treatment was to be presented in their P Client #1 was taken 3/5/2008, but he recommended durit have this client sed treatment. Interview Mental Retardation 4/4/2008 at 4:16pm Rights Committee (the action, and ther also have to consein presented on or file substantiate that the	-	€W 3	56)			
(W 436)	The facility must fur and teach clients to choices about the choices about the choices and other devices interdisciplinary tea interdisciplinary tea interview the facility of a leg brace for outpe facility. [Client:	m as needed by the client is not met as evidenced by: ion, record review and staff or failed to ensure the provision ne of eight clients residing in #4]	(w 4	36)	Cross reference W159		5/15/08
_	The finding include	5;					

#194 P. 008/015

04/73/5000 03:31 LWV TOT##70#nn

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(XX) DATE S COMPE	COMPLETED	
		09 G 035	B. WII	IG		54/	R 14/2008	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		311	et address, city, state, zip co 12 18th street NW Ashington, DC 20010	DOE		
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES I'MUST BE PRECEDED BY FULL SC DENTIFYING INFORMATION	ID FREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	DATE	
(W 436)	Client #4 was obse 4/4/2008 wearing h his leg brace. Staff belt, but it was not his leg brace. Inter Qualified Mental Re (QMRP) on 4/4/200 braces were not av and that the provisi pending. Record n was taken to an or refitted for the new there was no evide substantiate that the	aved on the afternoon of als gait belt but, he was without from the gait clear why he was not wearing view with the facility's elardation Professional 18 at 3:37pm revealed the legaliable at the time of survey ion of that orthotic device was eview revealed that Client #4 thopadic specialist to be braces on 2/18/2008, but ince at the time of survey to be facility followed through to ant received his adaptive	₹ W 4	36)				

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PRINTED: 04/23/2008 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1	PLE CONSTRUCTION	(23) DATE SU COMPLET	
				B, WING _	G	R	
NAME OF P	ROVIDER OR SUPPLIER	096035	STREET AD	DRESS, CITY,	STATE, ZIP CODE	04/04	/2008
CMS			3112 1311	H STREET N	rw .		
					<u>,</u>	TON	
(XA) ID PREFIX TAS	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORM	FULL	ED PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCE) TO THE APPR DEFICIENCY)	ULD BE	(75) COMPLETS CLATE
(1 000)	INITIAL COMMENT	ខេ		{ 000}			
{1 0 9 0}	initiated on 4/3/2008. The survite level of compliation (POC) were based on observell as a review of trecords, including a incident reports.	/14/2008 licensure s 8 and was completed by was conducted to moe to the deficienci- and as presented in). The results of the ervation, shaff intervi- the client and admini review of the unusure.	i on	(1 090)			
(1 030)	3504.1 NOOSENEE	FING		fi nant			ſ
	maintained in a safe and sanitary manne	erior of each GHMR e, clean, orderly, attr er and be free of rt, rubbish, and object	active,				-
-	Based on observation review, the GHMRP and exterior of each safe, clean, orderly,		cord interior ained in a ary			-	
							
,	Basement						
•		asoment near the do appeared to be wat ed as such.			Carpet will be replaced	•	5/15/08
	First Floor:					.	
		holder observed in t	he		Toilet tissue holder an rowel holder were insta	d paper lled.	4/28/08
lesith Regul	notertaining note	110		7	0		

LABOURTURY DRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

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	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIS IDENTIFICATION NU		(XZ) MULT	IPLE CONSTRUCTION	(XX) DATE S COMPLE		
	!	09G035		B, WING			₹ 4/2008	
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY.	STATE, ZIP CODE	•		
CMS				ISTH STREET NW HNGTON, DC 20010				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED BY 5C IDENTIFYING INFORM	PULL	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRINCED TO THE APPRIN	JLD BE	(XS) COMPLETE DATE	
{i 090}	Continued From pa	ge 1		{I 0a0}				
	bathroom and no paper towel holder was available in the first floor bathroom. 2. New small areas of brown stains were again.				5	9010014		
	observed on the cel According to the Qu Professional (QMRI	iling in the dining roo railified Mental Retain P), the areas were p not sure how or why	nn. dation reviously	·	Ceiling tiles were repla	ced.	4/30/08	
!	Exterior:				·	!		
	carpet installed on t	as were observed in the steps leading to t id a potential hazard	ne front		Carpet was replaced.	:	4/7/08	
	2. A tom area was oback porch is attach created a potential i	observed in the carpo had to the first step, t hazard.	at where which		Carpet was replaced.		4/7/08	
(1 222)	3510.3 STAFF TRA	UNING		(i 222)	Cross reference W159	:	5/15/08	
,		inuqua, ongoing in-s cheduled for all pers			Training was provided for gait bein.	or the	3/19/08	
	Based on observation review, the facility for received the proper resident's adaptive	met as evidenced by on, staff interview an alled to ensure that si and necessary train a equipment as requi of eight residents re at #4]	id record staff ling on a lired by		Training for braces will completed when braces and the facility.		6/1/08	
	The finding includes	52					•	
	for failing to ensure Resident #4 's ade leg brace). The fac	d during the 2/14/20 that staff received tr ptive equipment (get ility's Plan of Corre "the facility will trai	aining on t beit and ction		-			

#194 P. 011/015

04/23/2006 03:31 PAA 2024443430

PRINTED: 04/23/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER:		1	(CZ) MULTIPLE CONSTRUCTION (COMPLET A BUILDING R				
				E WING			4/2008
		09G035	PTREET AN	DRESS CITY I	STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			H STREET N		•	ļ.
CMS				TON DC 2			
DSA) ID	ST DESARRY STA	TEMENT OF DEFICIENCE	5	10	PROVIDER'S PLAN OF CORRECT	TION	COMPLETÉ
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY SC (DENTIFYING INFORM	FULL.	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ROPRATE	DATE
TAG	REGULATURY OR L	2C IDENTIFYING INFORM	411OFG	1746	DEFICIENCY		
{I 222}	Continued From pa	age Z		{1 222}			
	how to assist [Resi	dant #4] in walking w	ith the			•	
	gait belt and putting	on his braces. " T	nis i				
		was to be complete	d by		•		
	3/19/2006.						
	Resident #4 was o	bserved on the after	toon of				
	4/4/2008 wearing h	us gait beit but, he w	as without				ļ. ,
	his (eg brace, Staf	Twas observed using clear why he was no	ne gar				1
	his lea brace. Intel	rview with the facility	' 5	i			
	Qualified Mantal R	eterdation Profession	lej				
	(QMRP) on 4/4/200	08 at 3:37pm reveals	d the leg	1			
}	braces were not av	vailable at the time of ion of that orthotic de	Mice Mas Prive				
	panding. Record (eview revealed the f	aciffy was				
	not able to comple	te the training on the	use of the	'			
	leg braces, being t	hat the orthotic devic	e has not				
	been provided. [R	eference vv436)					.
1 392	3520 2(b) PROFE	SSION SERVICES: (BENERAL	1392	Cross reference W159		5/15/08
	PROVISIONS				ī		
	i Each GHMRP sha	il have available qua	lified	1			
1	professional staff t	s sanv out and moni	tor				Ţ ļ
	necessary profess	ional interventions, li	ا حة				Į
	accordance with the	ne goals and objective on plan, as determin	ed to be	}			
1	necessary by the l	on pian, as betermin nterdisciplinary team	. The				·
	professional service	es may include, but	not be			•	
	limited to those se	ervices provided by b	įdividuals		1		. '
1 .	trained, qualified, i	and licensed as required law in the following	Mercina Mercina				
	disciplines or area	a oj selajces: Briga III gle lamani	•				
							1
	(b) Dentistry;	•			ļ. ·		
	This Statute is no	t met as evidenced l	ly:			Ē	
	Based on staff into	erview and record re sure the provision of	view, the timely and		1		
	nécessary danial :	services and treatme	ent for one				<u> </u>
L							

Health Regulation Administration STATE FORM

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If configuration street 4 of 7

#194 P. 012/015

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) PLAN OF CORRECTION (DENTIFICATION NUMBER:		A, BUILDING	PLE CONSTRUCTION	(XX) DATE SURVEY COMPLETED R		
		0 9G 035		B. WING		04/04/2008
NAME OF B	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY. S	TATE ZIP CODE	
CMS				iton, DC 20	9019	
(XA) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	PULL	ID PREPIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
1 392	1 392 Continued From page 3 of eight residents residing in the facility. [Resident #1]			1392		
	The findings includ	e :				
The facility was previously cited for not ensuring timely dental services for its residents. According to the citation levied during the 2/14/2008 survey, the facility took the resident to receive dental services on 2/18/2007, 7/18/2007, and again on 1/29/2008, but for some reason the resident never received the following services:						
·	heavy calculus dep 2. Recommended 3. Treatment to a 4. Treatment to a Tooth #12	I to receive partial de ddress Ginglytts ddress the Carlous le I to receive Prophyla	entura esion on			
	that they would ensemble the treatment was to be presented in their I Resident #1 was to 3/5/2008, but he recommended duritave this resident treatment. Interview Mental Retardation 4/4/2008 at 4:18pm Rights Committee the action, and the also have to conseevidence presente	of Correction (POC) sure that "Resident of for dental follow-up a completed by 3/26. POC. Record review sken for dental treatment. Thing the 3/5/2008 consedated prior to recease with the facility 's a Professional (QMR or revealed that the H(HRC) would have the resident's broat. There was was led on or file at the timilate that this resident	#1 will ". This /2008 as / revealed nent on le dentist suitation to lving Qualified P) on luman or approve ther would no			

#194 P. 013/015

U4/23/2006 UD:DO FMA EUE44468450

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PRINTED: 04/23/2008 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLE IDENTIFICATION NU		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(XXI) DATE SURVEY COMPLETED	
		09G835		B, WING		R 04/04/2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CMS				H STREET N	0010		
(X4) IC PREFIX TAG	(EACH DEPICIENCY	TEMENT OF DEFICIENCIE MUST SE PRECEDED BY SC IDENTIFYING INFORMA	FULL	PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	VLD BE COMPLETE	
I 392	Continued From pa	.ge 4		1392			
	received the proper identified by his der	r and necessary treat nist to date.	lment as				
{(401)	3520,3 PROFESSI PROVISIONS	ON SERVICES: GEN	NERAL	(i 401)	Cross reference W159	5/15 /08	
	and evaluation, incl developmental leve services, and services	es shall include both luding identification o als and entification ces designed to prev her loss of function b	rf nent rent				
	Based on staff inter facility falled to ensi necessary dental se	met as evidenced by rview and record revi ure the provision of t arvices and treatmen esiding in the facility.	iew, the Imely and It for one	,			
	The findings include	9 ;	,	•			
	received the proper services to prevent	ed to ensure Resident and necessary dent the deterioration of honora beath as require a \$520.2(b)]	hal his onal		•		
	received the proper services to ensure	o failed to ensure Rea rand necessary orth the provision of a ne Federal Deficiency R	otic w leg				
(1 422)	3521.3 HABILITAT	ON AND TRAINING	;	(1 422)	Cross reference W159	5/15/08	
	and assistance to r	l provide habilitation, esidents in accordan vidual Habilitation Ph	ice with				

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#194 P. 014/015

U4/43/4000 U3.50 FRA 4029446900

PRINTED: 04/23/2008 FORM APPROVED

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1 7	(C2) MULTIPLE CONSTRUCTION (C3) DATE & COMPLE			
Ì		09G035		B MNG	· · · · · · · · · · · · · · · · · · ·		V2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE ZIP CODE			
CM5				13TH STREET NW HINGTON, DC 20010				
(X4) ID PREFEX TAG	PER (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S FLAN OF CORRE (BACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(AS). COMPLETE DATE	
{I 42Z}	Continued From pa	ge 5		{ 422}				
	Based on staff interfacility failed to add progression by a readministration progression in the facility was prevailed. The facility was prevailed to a program during the was previously cities requirements as fall Citation W252. Read-45pm revealed Read the first three steps of the self measures of the self measures.		aw the diack of adication idents Ing to eldent's The facility the Deficiency 008 at crefusing an first three					
	 Will pour cup o Will punch out assistance. Interview with the fix Retardation Profession	meds with physical acility's Qualified M sional (QMRP) at 3:	ental 55pm					
	program. The facil necessary oversigh the proper supports	on his self medication of his self medication in his self medication in falled to ensure the self and intervention to swhen a resident 's passe in a habilitation	en ensúre was	-	,			
(1 500)		'S RIGHTS dence director shall o sidents are observe		{I 500}				

Health Regulation Administration STATE FORM

To: HRA

05/02/2008 15:39

#194 P. 015/015

U4/23/2006 U2:80 PMA 4444444

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PRINTED: 04/23/2008 FORM APPROVED

STATEMENT OF DEPICIENCIES (X1) PROVIDENSUPPLIENCLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		R/CLIA MBER:	A BUILDIN	PLE CONSTRUCTION	COMPLU	COMPLETED R	
		09G035		B. WING_			4/2008
NAME OF #	ROVIDER OR SUPPLIER	414444	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CMS	WATER OR SOLVER		3112 1311	H STREET N	NV 0019	·	
(X4) ID PREFIX TAG	FACU DEFICIENCY	TEMENT OF DEFICIENCE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE HENCY)	COMPLETE DATE
(1 5 00}	chapter, and other laws. This Statute is not Based on observat review, the Group Persona (GHMRP) of each resident with DEMR Title 7	ige 6 lance with D.C. Law applicable District an entrance with D.C. Law applicable District and interview and the entrance for Mentally Reference for Mentally Reference for according to the entrance for District Chapter and on the entrance for District Chapter and on the entrance for the entrance for District Chapter and on the entrance for the	y: nd record starded the rights ordance er 13	{1 500}	·		
	The findings includ See federal deficie W189, W257, W35	ncý report citations \	N149,		Cross reference	W149 and W159	5/15/08
						_	

Health Regulation Administration STATE FORM

JIUL12

If combination sheet 7 of 7

#193 P. 002/015

04/23/2000 03:30 PAA 2024420430

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DEPART	IMENT OF HEALTH	I AND HUMAN SERVICES				FORM	04/23/2008 APPROVED
CENTER	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	8. MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(XX) N		IPLE CONSTRUCTION	(X3) DATE SIL COMPLE	TED
		09G035	B, WI				₹ 4/2008
NAME OF P	ROVIDER OR SUPPLIER			1	REET ADDRESS. CITY, STATE, ZIP CODE 1412 13TH STREET NW NASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(BACH DESIGNENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF YAC	<u> </u>	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ATIND BE I	(25) COMPLETION DATE
(W 000)	INITIAL COMMEN	rs ·	{w (X30)	,		
{W 149}	was initiated on A/3 4/4/2008. The sun the level of complic the previous report of Correction (POC were based on obseed on obseеd on obs	ect or abuse of the client. Is not met as evidenced by:	{w ·	149	The facility will proviing on incident managementers to staff.	ent, and	5/8/08
LABORGE	facility failed to ensurate policies and this section for all this section for all this section for all the facility was cit for failing to imples unusual incidents. Correction (POC) staff will be required injuries to Nursing facility 's Qualified Professional (QM) revealed there has incident managementhodology of re	erview and record review, the sure the implementation of its of procedures as required by clients residing in the facility. Section of the 2/14/2008 survey ment policies on reporting of the provider's Plan of detailed that "in the future and to attend additional training perment Policies and reporting staff." Interview with the inferior on 4/3/2008 at 3:11pm is been no training on the porting injuries to the Nursing perment policy or on the porting injuries to the Nursing			a am Muoda)	-5-	CONTRACTE 2-08
Apr deficien	NATALLE (Tax statement ending with	h un acterisk (*) denotas a deficiency w	AA hich the	7	button may be excused from correcting pro-	widing it is det	emined that
After saleg	uzuda provide eufficient p	rotection to the polients. (See instruction	ma, Ex	cept	to ministry pointies, the textures endistree of M	mection are di	ecionable 14

Any deficiency statement enting with an actarisk (*) denotes a deficiency which the inclusion may be accused from correcting providing it is determined that after an actual providing an actual providing it is determined that after an actual provide sufficient protection to the patients. (See instructions.) Except for number that sendings stated shows an disclosuble 14 following the date of survey whether or not a plan of correction is provided. For number that above findings and plans of correction are disclosuble 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

#193 P. 003/015

U4/Z3/ZU00 U3:50 PAA CUC44C545U

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES	& MEDICALD SERVICES (X1) PROVIDER/SUPPLIER/CUA (X1) PROVIDER/SUPPLIER/CUA	1		L'E CONZIENCIJON	(XX) DATE SU COMPLET	RVEY (ED)
and Plan O	F CORRECTION		B. WI			F 04/04	₹ 1/2008
NAME OF F	ROVIDER OR SUPPLIER	09GU35	1	34	PPT ADDRESS, CTY, STATE, ZIP CODE 112 13TH STREET NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	/CACU DEDICIENC	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEHCHENCY)		COMPLETION DATE
{W 149}	RETARDATION PI Each client's active integrated, coordin qualified mental re This STANDARD Based on observar review, the facility active treatment pi coordinated and m Mental Retardation dients residing in The findings include 1. The Qualified Professional (QMI received the propertient 's orthotic d 2. The Qualified Professional (QMI oversight and mo show progress on [Reference W257 3. The Qualified Professional (QMI raceived the prop services. [Reference 4. The Qualified Professional (QMI received the prop services. [Reference]	### ### ### ### ### ### ### ### ### ##	- wy	•	1. Client #4 will recieve devices when Medicaid as payment for the orthotic. The facility will provide documentation indicating Client#4 was measured forthotic devices. 2. The nursing staff will documentation that Clieunable to participate i medication program due fractured toes. 3. QMRP will provide downers Client#1 refused care twice. Client#1 with the dentist again in to provide him with dental control of the dental care with the dental care	uthorize c device de writt g when or the ll provi nt#1 was n his to his cumentat dental ll1 retur n an atte	5/15/08 de 5/15/08 don
1	equipment [Refe	erence W436]	1				L

To: HRA

05/02/2008 15:41 #183 P. 004/015

04/23/2000 03:50 PAA CUARREDGO

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) FROM		(X1) PROVIDER/SUPPLIER/CLIA	(DC2) N	ULTI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAND	F CORRECTION	IDENTIFICATION NUMBER	i .	LDING	•		
•		09 <i>G</i> 035	B, WI	NG_	<u> </u>	,	V2008
NAME OF P	ROVIDER OR SUPPLIER		_1	31	DET ADDRESS, CITY, STATE, ZIP CODE 112 13TH STREET NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	-1X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DETICIENCY)		COMPLETION DATE
(W 189)	The facility must pr	FF TRAINING PROGRAM uvide each employee with g training that enables the m his or her duties effectively, spetently.	{W 1	189}	OMRP will provide train staff once Client#4 rec his braces.		6/1/08
	Based on observat review, the facility in received the propa- client's adaptive of	is not met as evidenced by: jon, staff interview and record leiled to ensure that staff r and necessary training on a equipment as required by this eight clients residing in the			-		
	The finding include	15 :			·		
	for failing to ensure Client #4 's adapti brace). The facility detailed that "the assist (Client #4) in	ed during the 2/14/2008 survey that staff received training on we equipment (gait bett and leg y's Plan of Correction (POC) facility will train staff on how to walking with the gait bett and es. " This corrective measure ad by 3/19/2008.					
	A/A/2008 wearing his leg brace. State beft, but it was not his leg brace. Inter Qualified Mental F (QMRP) on A/A/20 braces were not and that the proving pending. Record not able to comple	arved on the afternoon of this gait belt but, he was without if was observed using the gait clear why he was not wearing arview with the facility 's tetardation Professional 108 at 3:37pm revealed the leg vallable at the time of survey sion of that orthotic device was review revealed the facility was the training on the use of the trait of the device has not deference W436]					

04/23/2008 03:56 PAA 2024428400

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	l'OF DÉMICIENCIES DE CORRECTION	(X1) PROVIDENSUPPLIENCIA IDENTIFICATION NUMBER:	(CS) M		RE CONSTRUCTION		COMPLE	TED	
		89 G 035	B. WI	NG _		_	1	R 4/2002	
NAME OF P	ROVIDER OR SUPPLIER			.3	RET ADDRESS, CITY, STATE, 112 13TH STREET MW VASHINGTON, DC 20010		CODE .		
(244) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAS		PROMIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION 5HO	ULD BE	(208) COMPLETION DATE	
W 257	CHANGE The individual proglesst by the qualifier professional and rebut not limited to sifulling to progress to after reasonable affirm the standard on staff interfacility failed to add progression by a clipadministration progression in the facility that finding includes the facility was presiding in the facility was president additional and the facility was president	• • •	w:	2257	Cross reference	W159		5/15/08	
	program during the was previously ofter requirements as lall on 4/4/2008 at 3:45 been refusing the firmedication program. The first three step program are as follows: 1. Approaches hu. 2. Will pour cup of 3. Will punch out interview with the firetardation Profes revealed she was reprogressing poorly	2/14/2008 survey. The facility of for falling to meet the id out in W252. Record review ipm revealed Client #1 has irst three steps of his self in since the date of survey. If the self medication ows:							

#193 P. 008/015

84/23/2000 03.00 PMA 49444P4P

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION MURBER:		1 '	PLE CONSTRUCTION	(CS) DATE SURVEY COMPLETED		
		-	A. BUILDIN		DAMA	/2008
22245 67 5	ROVIDER OR SUPPLIER	09G035		CET ADDRESS, CITY, STATE ZIP CODE	040-	2000
CMS	KOVIDER OR OUT FLIEN] 3	112 13TH STREET NW VASHINGTON, DC 20010		
(X4) ID PREFIX TAG	TEACH DÉFICIENC	TEMENT OF DEPICIENCIÉS Y MUST 95 PRECEDED BY PULL SC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S FLAN OF CORRECT (BACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEPCIENCY)	ULDBE	(756) COMPLETION DATE
W 257 (W 356)	the proper support show progress in a	ige 4 It and intervention to ensure Is when a client 'a is failing to I habilitation program. IPREHENSIVE DENTAL	W 257 (W 356)	Cross reference W159		5/15 /08
	treatment services needed for relief of	nsure comprehensive dental that include dental care f pain and infections, , and maintenance of dental	•			
	Based on staff into facility failed to ens necessary dental s	is not met as evidenced by: erview and record review, the sure the provision of timely and earvices and treatment for one iding in the facility. [Client #1]				
	timely dental sarvi- to the citation levie the facility took the services on 2/18/2 1/29/2008, but the following services.	le: evicusly cited for not ensuring ces for its residents. According to during the 2/14/2008 survey, edjent to receive dental 1007, 7/16/2007, and again on client did not received the render was unknown to the				
	heavy calculus de 2. Recommende 3. Treatment to 4. Treatment to Tooth #12	id to receive partial denture				

To:HRA

05/02/2008 15:42

#193 P. 007/015

04/63/6000 03.31 PMA 4064410440

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	S FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLA	(2CZ) M	ULTIPI	E CONSTRUCTION	(X2) DATE SU COMPLE	
AND PLAN OF	FORRECTION	DENTIFICATION NUMBER:	A BUD			1	٦
		09G035	B, WIN			04/04	4/2008
NAME OF PE	ROVIDER OR SUPPLIER			311	et address, city, state, zip code (2 13th street NW Ashington, DC 20010		
(X4) ID PREFIX TAG	ACTOR DESCRIPTION	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL LEC IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH) CROSS REFERENCED TO THE AFF DEFICIENCY)		PATE TAND
(W 356)	that they would so		{W 3	56)			
	treatment was to be presented in their Client #1 was take 3/5/2008, but he recommended durinave this client se treatment. Intervisional Retardation 4/4/2008 at 4:16 presented on or firsubstantiate that is proper and neces his dentist to date	the completed by 3/26/2008 as POC. Record review revealed on for dental treatment on efused treatment. The dentiating the 3/6/2008 consultation to dated prior to receiving the with the facility's Qualified in Professional (QMRP) on revealed that the Human (HRC) would have to approve on the client's brother would ent. There is was no avidence lie at the time of survey to this client has received the sary treatment as identified by					5/15/08
(W 436)	The facility must and teach clients choices about the hearing and other and other devices.	ACE AND EQUIPMENT furnish, maintain in good repair, to use and to make informed a use of dentures, eyeglasses, r communications aids, braces, s identified by the earn as needed by the client.	{w	436)	Cross reference W159	·	37.13700
	Based on observ	Is not met as evidenced by: ation, record review and staff lity failed to ensure the provision rone of eight clients residing in at #4]			•	•	
	The finding inclu	d es :				l continuention of	h

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05/02/2008 15:42

#193 P. 008/015

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO.	04/23/2008 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V BANTO	TIPLE CONSTRUCTION NO	(XS) DATE SI COMPLE	
		096035	B. WING		1	4/200B
• • • • • • • • • • • • • • • • • • • •	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZI 3112 13TH STREET NW	CODE	•
(XA) ID PREFIX TAG	(SACH DEFICIENC)	ATEMENT OF DETICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTE-VING INFORMATION)	ID PREFIX TAG	WASHINGTON, DC 20010 PROVIDER'S FLAN OF (EACH CORRECTIVE AC CROSS-REPERENCED TO DEFICIENT	THE APPROPRIATE	<i>ps</i>) coni-lenon date
(W 435)	4/4/2006 wearing his leg brace. Staff belt, but it was not his leg brace. Intel Qualified Mental R (QMRP) on 4/4/200 braces were not avand that the provisionant pending. Record or refitted for the new there was no evide substantiate that the	erved on the afternoon of als gait belt but, he was without if was observed using the gait clear why he was not wearing release with the facility of elardation Professional 18 at 3:37pm revealed the leguraliable at the time of survey larn of that orthotic device was eview revealed that Client #4 thopedic specialist to be thraces on 2/18/2008, but these at the time of survey to be facility followed through to entireceived his adaptive	(W 436			

04/23/2000 03.21 TAE 2015410400

05/02/2008 15:42

#183 P. 009/015

PRINTED: 04/23/2008 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILDIN	PLE CONSTRUCTION	(CG) DATE SU COMPLE		
		09 G 035		8' MINC -			1/2 008	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, I	TATE, ZIP CODE	 -		
CMS			3112 13TI WASHING	STREET NOT ON, DC 20	3010			
(X4) ID: PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	9D PREFIX TAG	PROVIDER'S PLAN OF CORRECT (BACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR (DEFICIENCY)		COMPLETE DATE	
(I 00 0)	INITIAL COMMENT	rs		(t 000)			·	
	Initiated on 4/3/2008. The survival lavel of compliate the previous report of Correction (POC were based on obside as a review of records, including a incident reports.	/14/2008 licensure s 8 and was completed rey was conducted to noe to the deficiency and as presented in). The results of the ervation, staff intervi- the client and admini review of the unusu	d on assess es cited in their Plan survey ews, as istrative					
{1 090}	3504.1 HOUSEKE	EPING		(I 090)			1	
	maintained in a saf and sanitary manne	terior of each GHMR e, clean, orderly, attr er and be free of irt, rubbish, and obje	ective,		·	·	·	
	Based on observation review, the GHMRI and exterior of each safe, clean, orderly manner and be free rubbish, and object		cord interior tained in a tary				•	
	The findings includ	e ;	f					
	Basement		İ					
-		asement near the do n appeared to be wal ned as such.		<i>,</i> •	Carpet will be replaced	. .	5/15/ 08	
	First Floor:							
		holder observed in	the		Toilet tissue holder an rowel holder were insta	d paper illed.	4/28/08	
Health Regg	lation Administration			r	(A) TOTAL (A)		CKEN MATTE /	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE PROJECT OF STATE FORM

STATE FORM

JULIZ

#193 P. 010/015

04/23/2005 UJ:51 FAA 2064428450

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	TOF DEFICIENCES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NO		(XZ) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SI COMPLE	TEP	
				B. WING_			₹ 4/2008	
		89G035	CONTRACT AND	NOCOC (NTV I	STATE, ZIP CODE		42.000	
NAME OF P	ROVICER OR SUPPLIER			H STREET N				
CMS				IGTON, DC 20010				
(XA) ID PREFIX TAG	reach deficiency	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCIDENTIFYING INFORMA	PULL	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (PACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		CONTRACTE DATE	
{I 090}	bathroom and no paravailable in the first 2. Now small area observed on the ce According to the Quarter of the Quarter of the Quarter of the paired and she is stains are returning Exterior: 1. Several torn are carpet installed on porch, which create back porch is attack	aper towel holder was a floor bathroom. It is of brown stains we ding in the dining roculatified Mental Retarmed Mental Retarmed to sure how or why the steps leading to observed in the carp thed to the first step,	are again om. dation reviously the the front et where	(I 090)	Ceiling tiles were replaced. Carpet was replaced. Carpet was replaced.	aced.	4/30/08 4/7/08 4/7/08	
	training programs a This Statute is not Based on observat review, the facility is received the properesident a sadaptive this section for one the facility. [Resident for facility was cite for falling to ensure Resident #4 a sadaptive the facility to ensure	AINING tinuous, ongoing in-secheduled for all pen met as evidenced b ion, staff interview at failed to ensure that is a equipment as required of eight residents re ent #4]	y: nd record staff ning on a lired by esiding in 008 survey training on it belt and ection	(† 22 2)	Cross reference W159 Training was provided f gait bilt. Training for braces wil completed when braces a the facility.	1 be	5/15/08 3/19/08 6/1/08	
STATE FOR					JUL12	# continu	ation sheet 2 of 7	

#193 P. 011/015

04/23/2008 03:57 FAX 2024428430

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:		(CE) MULTIPLE CONSTRUCTION A BUILDING		COMPLETED			
	99G035		g wing_		04/04	1/2008		
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE			
CMS	C M S 3112 13TH STREET NW WASHINGTON, DC 20010							
(XA) ID PREFIX TAG	(EACH DEPICIENC)	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY SE IDENTIFYING INFORMA	FULL !	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETE DATE	
{ 222}	Continued From pa	age 2		(1 222)				
	gait belt and putting corrective measure 3/19/2008. Resident #4 was of	dent #4] in walking w j on his braces. " Ti was to be complete bserved on the after	nis d by laon of			-		
	his leg brace. Staff belt, but it was not his leg brace. Inte Qualified Mental R (QMRP) on 4/4/20/ braces were not avand that the provis pending. Record r not able to comple	is gait belt but, he was observed using clear why he was no released with the facility etardation Profession 08 at 3:37 pm reveale vallable at the time of ion of that orthotic desvice revealed the fata the training on the that the orthotic device ference W438)	the galt wearing 's rel id the leg survey svice was scilly was use of the					
1 392	3520.2(b) PROFE	SSION SERVICES; (SENERAL	1392	Cross reference W159	-	5/.15/08	
	professional staff to necessary professional accordance with the individual habilitation necessary by the inprofessional service limited to, those settlemed, qualified, a	Il have available qua to carry out and moni- ional interventions, in the goals and objectivion plan, as determin- nterdisciplinary team cas may include, but arvices provided by in and licensed as requilal law in the following as of services:	tor content					
	(b) Dentistry;				· ·			
	Based on staff into	t met as evidenced to arview and record re- sure the provision of services and treatme	view, the timely and					

#183 P. 012/015

04/23/2008 03:57 FAA Z024428440

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STATEMENT OF DEPICIENCES AND PLAN OF CORRECTION DENTIFICATION NUMBER: UPG035		pc) multi a Burdin b Wing _	G	COMP	COMPLETED R 04/04/2008				
NAMEGER				DRESS CITY !	STATE ZIP CODE				
CMS	3112 13TH STREET NW								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PROPEX (BACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(XE) COMPLETE DATE				
(392	Continued From particles of eight residents re [Resident #1] The findings included the facility was pretimely dental service to the citation levied the facility took the services on 2/18/20/1/29/2008, but for snever received the snew frestment to a snew frestment to a snew frestment to snew frestment fres	ge 3 esiding in the facility. es evicusly cited for not less for its residents. d during the 2/14/200 resident to receive door, 7/18/2007, and a come reason the resident following services: If to receive scaling diseases Ginglyitis defress Ginglyitis defress the Carlous in the receive Prophyla	ensuring According 18 survey, lental again on ident lue to enture eston on pds and detailed \$1 will ". This 72008 as revealed nent on is dentist suitation to iving Qualified	1392	DEFICIENCY				
	4/4/2008 at 4:18pm Rights Committee the action, and the also have to conse evidence presents	n revealed that the H (HRC) would have to In the resident 's bro Int. There was was I d on or file at the tim late that this resident	uman approva ther would no e of			•			

#193 P. 013/015

U4/23/2006 UJ:06 PAA 2024428430

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PRINTED: 04/23/2008 FORM APPROVED

	TEMENT OF DEFICIENCIES OF LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(C2) MULTIPLE CONSTRUCTION A BUILDING		COMPLETED			
	p9G035		a Ming_			•/z008		
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE			
CMS	WASILINGTON, DC 20010							
(X4) ID PREFIX TAG	(EACH DÉFICIENCY	TEMENT OF PEFICIENCIE MUST DE PRICEDED BY SC IDENTIFYING INFORMA	FULL	ID PREPIX TAG	TION ULD SE CPRIATE	COMPLETE DATE		
1 392	Continued From pa	ge 4		1392	,			
	received the proper identified by his der	and necessary treat trist to date.	pwevr siz					
{ 401}	3520.3 PROFESSIONS	ON SERVICES; GEN	NERAL	{1 401}	Cross reference W159		5/15 /08	
	Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.							
	This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the provision of timely and necessary dental services and treatment for one of eight residents residing in the facility. [Resident #1]							
	The findings include	Dt.			,			
	1. The facility failed to ensure Resident #1 received the proper and necessary dental services to prevent the deterioration of his oral health and loss of more teeth as required by this section. [Reference 3520.2(b)]		tal nis oral					
	received the proper services to ensure t	i falled to ensure Real and necessary ofth the provision of a ne rederal Deficiency R	otic w leg			-		
(1 422)	3521.3 HABILITATI	ION AND TRAINING	•	{1 422}·	Cross reference W159		5/15/08	
	and assistance to n the resident's indi	provide habilitation, esidents in accordan vidual Habilitation Pic	ice with	•				

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To: HRA

05/02/2008 15:44

#183 P. 014/015

04/63/6000 03.00 FAA 6064460400

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PRINTED: 04/23/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (M) PROVIDER/SUPPLIER/CLA (DENTIFICATION NUMBER: (99035		(X2) MULT A. BUILDI B. WING		COMPL	COMPLETED R 04/04/2008		
NAME OF P	PROMDER OR SUPPLIER	,	3112 13T	ADORESS, CITY, STATE, ZIP CODE ITH STREET NW NGTON, DC 20018			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL.			PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
(T 422)	Continued From page 5			{ 422 }			
	Based on staff interfacility falled to addition progression by a readministration progression in the facility was presiding in the facility was present accurate do program during the program during the requirements as laked Citation W252. Read 3:45pm revealed Refer the first three steps program since the citation of the first three steps program since the citation of the citation was provided the first three steps program since the citation was a steps program since the citation was a steps of the citation was a steps of the citation was a steps of the citation was a step of the ci	J D (ew the . I lack of adication addents g to sident's The facility he Deficiency 2008 at refusing n			-	
	Approaches nurse for meds independently. Will pour cup of water for meds. Will punch out meds with physical assistance.				·		
	Retardation Profess revealed she was no progressing poorly of program. The facility necessary oversight the proper supports	ucility's Qualified Me sional (QMRP) at 3:5 of aware Resident # on his self medication by failed to ensure the t and intervention to when a resident's verses in a habilitation	5pm 1 was n e eńsure was	·			
(1 500)		S RIGHTS ence director shall e iidents are observed		{ 500}	·		

Health Regulation Administration

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' If contingation shout 6 of 7

#193 P. 015/015

U4/Z3/ZUU0 U3:50 FAA 2024468440

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:			(XZ) MULTIPLE CONSTRUCTION A. BUILDING			(XX) DATE SURVEY COMPLETED		
j	09G035		B MING		R			
			DEESS CITY	STATE, ZIP CODE		04/0	4/2008	
CMS		·	3112 13TH WASHING	H STREET I	NW			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDERS PLAN OF (EACH CORRECTIVE ACT CROSS REFERENCED TO 1 DEFICIENCE	COMPLETE DATE		
(1 500)	chapter, and other a laws. This Statute is not a Based on observation review, the Group H Persons (GHMRP) of each resident with DCMR Title 7 S (Formerly PL 2-137) applicable laws. The findings include	ance with D.C. Law 2 applicable District and met as evidenced by: on, staff Interview and forme for Mentally Reliated to ensure that it is protected in accomplishment of the chapter and other and other chapter and chapter	i record barded te rights dance r 13	{1 500 }	Cross reference Wi	49 and	W159	5/15/08
leath Recul	iton Administration	·						

STATE FORM

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if continuation sheet 7 of 7

GOVERNMENT OF THE DISTRICT OF COLUMBIA Department of Health

Health Regulation Administration



SAMPLE SELECTION FORM

Survey Period

From: March 25, 2009

To: March 26, 2009

Provider Name:	DC Health Care 4601 Georgia Avenue NW	Provider Number:	O9G-046

Names	Functional Level	Core	Add-On	Client Identifiers
DONALD MCCOY	PROFOUND	Х		CLIENT #1
KENNETH BURGESS	SEVERE	Х		CLIENT #2
PHILLIP ROSE	PROFOUND	Х		CLIENT #3
MARCELLUS BRUCE	SEVERE	х		CLIENT #4
ROLAND MINOR	SEVERE			CLIENT #5
AARON COOPER	PROFOUND			CLIENT #6
MARK WILSON	Profound			CLIENT #7

Roland Follot/Michael D. Walker	March 26, 2009
Surveyor(s)	Date